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ABSTRACT

Psychotherapy with older dying patients can lead to problems of countertransference for the clinician. Working with dying patients requires flexibility to adapt basic therapeutics to the institutional setting. Goals of psychotherapy must be reconceptualized for dying clients. The problems of countertransference arise because clinicians themselves are not prepared for death. In therapy the clinician too is caught up in waiting for the death of the client. The sights and smells of terminal illness may be repulsive to the clinician. Therapy with dying clients and their families must be time flexible; therapists are needed at irregular times. Therapists should assist clients in the productive use of defense mechanisms in the dying process. A therapeutic relationship is best established as soon as the client knows he or she is dying. The therapist can help clients to determine the best use of remaining life and aid them in reviewing their life constructively. Dying people need to retain as much control of their lives as possible, especially in the face of medical intervention and pain. As the client becomes more isolated from people, therapists can provide needed support. The therapist should remember that clients have little energy for emotional therapy. Finally, all dying people are not in need of therapy; many already have their own personal philosophies which help them cope with death. (ABL)

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Psychotherapy with older dying persons

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Abstract

The process of psychotherapy with older dying persons is a significant personal and professional challenge. Basic countertransference issues of vulnerability and existence must be resolved. Problems relating to the structure, goals, meaning of the therapeutic relationship, and progress in that relationship must be accommodated. These processes and some of the content issues that arise in working with dying patients are discussed. Some of the content issues discussed have to do with time confrontation, separation and isolation, waning energy, dependency, etc. Differentiation of the psychotherapy with older and younger dying clients is made.

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PSYCHOTHERAPY WITH OLDER DYING PERSONS

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Psychotherapy with older dying patients is one of the most demanding areas within which a clinician can practice. This is so because of the countertransference problems and the on-going nature of the therapy involved. The countertransference problems are perhaps the most difficult to accommodate and resolution of these problems is a tremendous personal challenge to the clinician. Much has been written about the problems experienced by clinicians who work with older adults in any setting and for whatever reason, in terms of this client population stimulating fears about death, arousing concerns about vulnerability, loss, decline in functions and the such. Indeed, if the older client poses such problems, then the dying client is an even greater threat.

Additionally, the special challenges of working with dying patients come from the structure, process and content of the therapeutic encounters with these clients. Work with dying patients requires that the therapist be quite flexible and versatile. The therapist must have at hand the usual armamentarium of approaches from the basic therapeutic systems, as well as family therapy, a background of experience in working with the environmental factors that influence behavior within institutions, and facility in the application of the principles of health psychology. Work with dying patients requires a reconceptualization of the goals and role of psychotherapy and the meaning and usefulness of defense mechanisms. I will elaborate on these processes as I discuss the issues of dying, but let me return to the countertransference problems for a moment.

Death is no longer seen as a natural end to life in our society, but instead as a fault of technology or a failure of those who work within the area of health care. Consequently, the opportunity to deal intelligently with the end of life gets lost in the frenetic attempt to prolong it. So, few people prepare themselves for death or even think about it much, and then too, practice in dying is naturally limited. Those who become clinical psychologists are no different in their experience and attitudes in this area. They experience this death phobia the same as others, and there are other negative factors connected with working with dying clients. For example, the sights and smells of the illnesses that are likely to accompany terminal illness are often revulsive. Also, the termination of psychotherapy with these clients is a death that comes at an unknown point in time. The therapist is caught up in the same state of waiting and is subject to the same lack of control as the client. Lack of control may be experienced by the therapist during the course of the therapy as well because of the need to tolerate some of the defensive maneuvers of the client. Consequently, few are prepared for the strong reactions that are aroused in initial contacts with the dying or know how to deal with them except to avoid further contact. And, there are few peers to provide role models, give support or help in developing the means of coping with the problems that arise. Becoming a therapist for older, dying persons is a rather lonely, ego-endangering venture. How does any one mortal overcome these problems? The first step in handling this countertransference is that the therapist must develop some personal philosophy about life, living and death that will provide the necessary tolerance and buffer, and that will allow for further exploration in this area. This philosophy is not one to be taught to the client. Clients must be helped to develop their own way and to use their own strengths in dealing with this situation through the therapy. The philosophy for the therapist is necessary so that the client can freely explore the options and the anxieties as well. Not only does the therapist have to have this useful philosophy but also must have ongoing personal support and reinforcements to reaffirm life on a daily basis.

In addition to the countertransference problems, therapy with dying clients makes other unique demands on the clinician. The therapist must be flexibly available as new problems and crises arise. Dying clients and their family members may need access to the therapist at irregular times as new concerns arise. These may not fit neatly into 50 minute hours one or two times a week. There may be sudden requests for sessions and cancellations of appointments. The nonappearance or lateness of a patient for a session will probably be due to real interfering events rather than to psychological resistance. Flexibility of the therapist may be required as the physical status of the patient alters causing momentary changes in the ability to relate and to exert cognitive control. This is a problem, for example, in the case of brain metastisis with certain cancers. Therapeutic encounters may occur in the waiting room of yet another test to be done or a treatment to be taken as the therapist reinforces relaxation or antiemtic procedures, at the bedside of the client in a double room with a roommate present, or perhaps in the privacy of an office. Therapist and client learn ways to create conditions of confidentiality in the midst of a crowd. If the client is in the hospital, sessions may need to be fit in between medical tests, visits, etc. Sessions may be of varying lengths due to the particular level of energy or pain of the client at the time. The therapist and client must utilize a precious few moments that become available as well as longer time periods they might have used during a less crisis oriented time.

The role of the psychotherapist in this setting is to provide safe conduct for the client through the dying process. The therapist must provide acceptance of regressive processes, provide clarity, candor, compassion, and accessibility. The therapist must reconceptualize the meaning of defense mechanisms in terms of their utility for the special process of dying. In other contexts the therapist may deal with defensiveness rather directly, but in this situation some defenses may be fostered. Defense mechanisms temper psychological progress toward death and make that progress tolerable. The therapist must weigh quite carefully the costs and the benefits of discouraging defenses and of facing the client with the 'reality' of the situation. And, with each encounter with the client there must be this careful evaluation of the tolerance at that moment for resolution of issues since tolerance changes with differences in pain, energy levels and other occurrences. The therapist may find that a client is alternatively open to exploration of the issues of dying and at other times surprisingly defensive.

Not only the tolerance for but also the interpretation of psychological reactions as defenses need to be carefully evaluated. For example, dependence may need to be allowed to older dying clients in a way that may not be tolerated in other therapeutic relationships. This would be especially true of older clients without families. As another example, the type of reaction labeled 'denial' is frequently seen at this time. As a defense there may be denial of the fact of illness, of the implications of illness and of extinction. On the other hand, what is seen on the surface as denial may not be the intrapsychic defense we all know, but rather a social strategy to ensure against the loss of relationships. Or, it may be a sign of an effective philosophy of life and dying, or the successful resolution of pertinent issues. The correctness or lack of these alternate interpretations will be obvious as the therapist observes the other behaviors and verbalizations of the client within the therapy situation, with family members, or with other dying persons with whom they may be in contact. Also, what we see as denial may really be a manifestation of hope. As therapists it's important not to destroy hope in these clients, and it is also important not to be supportive of a blind hopefulness because as the promise of sure and long life dims

for the patient, the therapeutic relationship may be destroyed. The object of the hope will change over the process of dying from eagerness for cure or remission early in the process; to hope for pain-free moments or days later on; to hope for the comfort of those left behind as the client comes closer to the actual moment of death.

In the process of dying different illness and death related issues arise. I have not found these to appear in any stage related fashion. In a very real sense, each person dies his own death, and the salience, presence and order of issues depends on the person doing the dying. No matter how people do their dying, however, there are many potential points for therapeutic intervention. Optimally, work with the client would begin soon after it is learned that death is imminent so that an effective working relationship could be established. This will be the time when the client has more energy and perceived time, and it's the point at which quality of life for the rest of the process of dying can be established.

As the individual begins this last stage of life, the realization of what is about to happen is the most important problem immediately facing that dying person. This occurs within the context of the hopes of remission or cure of illness and the struggles of the individual and loved ones for continuing life. At this point the perspective of the dying person changes and a confrontation with time occurs. The dying client and family begin an accounting of how many moments are yet left, how to utilize these best, and what moments have been lost and will never be available to live. Now, older people usually reflect some appreciation of this process, and the therapist can build on beginnings that have been made. It is the same attitude that may be heard from those who were once close to death such as hostages, by persons who 'come back from the dead', those who get a reprieve from illness, etc. The individual can experience a flight into life at this time that may be a denial of the situation. Or gradually, the client may come to grips with living life constructively, finishing tasks that can be done, and addressing those issues that are the most important. The role of the therapist at this point is so important in mobilizing the energies of the client for living to help them renew the emotional participation in the life that remains, in helping the client determine how best to use whatever time is remaining to him or her to program for successive stages and events toward death, and continue activities that reinforce positive self-image and gratifying relationships. This will help them fight depression and anxiety and provide a sense of control.

Another part of the time confrontation process is a shift in focus from living toward the future to living in the present and perhaps reliving the past. In the process of determining how best to utilize the remaining time left, the older adult may begin a review of past life to determine what unfinished tasks are left. This process can develop into a meaningful exploration and satisfying integration of their life into some overall apparent theme. The significance of one's life can come from many sources - one's creative influences, one's children, the influence of life work on others, on relationships, etc. The individual can draw strength from these past successes to continue positive participation in life at the present as energies wane. The therapist can assist and enhance this process of constructive reminiscence and life review. Again, older adults tend to do some of this life review, but often times they will experience more of a process of simple recalling past events. With the help of a therapist a deeper more meaningful and satisfying exploration as suggested by the approaches of so many theorists, may be accomplished.

As the individual progresses toward death, it is likely that there will be more visits for medical care as treatments are attempted to prolong life, reduce pain and discomfort, or as problems related to the primary illness arise. A major

therapeutic issue at this time becomes that of maintaining control and instrumentality in one's life. The dying person often feels that control of life has been lost because of the finite amount of time left and also because of the limitations imposed by progressive loss of energy and increased discomfort. The situation of obtaining medical care only accentuates and deepens that feeling. In addition, well meaning and loving family members, wanting to show their love, rush in to do too much for the relative. Dying people may be hindered in attempts to maintain functioning, become infantilized and reactive in the situation instead of a decision-maker within it. Dying persons often feel most vulnerable with hospital staff because they reason that if they demand too much, they will be ignored and then none of their needs in the situation will be met. Things get worse because as energy wanes, there is the real need for more to be done for the dying patient. Dependency needs in this situation are real, but they arouse all sorts of emotions that must be dealt with. This may be a point at which the therapist's knowledge of environment-person influences may facilitate care in helping both parts of the health care effort - patient and staff- understand and work with each other better. This might be done through staff development within the institution (hospital, nursing home, etc.) or through consultation with family to modify the home environment in physical and interpersonal ways and other ways. Also the client's control may be enhanced by participating in the resolution of some of the care issues that may arise such as the decision to code or not, for tube feeding, feeding, physical restraints, or the place of death. A very crucial area of control is in the management of pain. The therapist may teach and reinforce psychological pain control methods such as relaxation, medication, distraction, humor, etc. These are procedures that enhance the patient's sense of control and are frequently immediately rewarding. Assertiveness and social skills' training are useful here too in helping the patient handle family and staff so that they may provide more appropriate care.

Another major area of concern for the dying person is that of separation. This is important to the person who is dying as well as to family, friends, etc. The patient both anticipates separation and experiences it as death approaches. Isolation is a difficult fact of life for the dying individual. Friends fall away as the physical appearance and energy of their acquaintance declines and if the dying process wears on for any length of time, probably no friends will remain to visit. This isolation affects both the patient and the family. Relatives complain of the loss of support that this illness or death phobic behavior means. In addition to combating isolation as a living separation experience, the dying patient is faced with anticipated real losses because of death of the relationships, experiences, objects, etc. that have become meaningful over a life time. Both the dying patient and the family need support at this time and help in directing their lives and energies in the most productive directions. The things to be lost may need to be mourned. Mourning is an active process of recalling and evaluating all the entanglements and meanings with the thing to be lost, and a withdrawing of the investments in that object. Mourning is a natural process and something a psychologist can assist in to make it complete and to keep it from becoming depression which is not a natural process. What therapeutic approaches are best used at this time? The cognitive and behavioral approaches seem best suited to the dying client from my vantage. They are quickly utilized when time is so limited, and easily adapted when energy prevents much physical activity.

At the last point of dying, just before death, the client doesn't have much energy to do active psychotherapeutic work. Psychologically there is little tolerance for

exploring conflicts and issues. The patient turns toward discussions and conversations that demand little energy, and resists heavily emotion-laden topics. Family members are usually quite distressed by this behavior in their loved one. They usually want greater and more meaningful interactions than their relative is willing to give. The therapist unfamiliar with the client will note at this point a resistance in the individual for beginning any new relationship including one with the therapist. If the therapist has worked with the older adult before this time, the constancy of the relationship built over that period of time will be reassuring to the individual. Being emotionally assessable without being in distress like family members are likely to be, can be quite supportive to the patient.

At this point the therapist's most active psychotherapeutic job may be to spend more time with the family in readiness for the post-death bereavement period. This will be comforting for the client too, knowing that the emotional needs of family members will be met. Often dying persons are not so concerned for themselves as for those they leave behind. Knowing of the constancy of a person who can provide emotional care and support relieves some of the anxiety that may arise in this area.

How should I conclude a discussion of psychotherapy with older dying persons? Perhaps a qualifier to the amount of need there is for psychotherapeutic work at this time would be appropriate. Not all people require psychotherapeutic intervention at this time. Those who view aging and death from outside that process may be surprised that this may be so since trauma is perceived as the only possible reaction. Therefore all dying clients would need help. Therapists who work with older dying persons will note that a great number of them have begun to think about life as having a time limit and have begun to develop a philosophy that will help them through the period of dying. And, they are also likely to have supportive family members that can provide the buffer and support that is needed at this time. These individuals may need to resolve the issues to be discussed but they are able to do so within their own family grouping. Those who aren't so buffered by philosophy or meaningful relationships may indeed be able to use the help that a therapist can provide.

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